Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-3666-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: FIDELITY & DEPOSIT CO OF MARYLAND Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on the Table of Disputed Services: "necessary pain management"

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Total Amount Sought $422.36*

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "If it is determined any prior or interim payments by Carrier were for inappropriate care, are excessive or are otherwise not in accordance with law, Carrier requests the Division order a refund under authority of one or more of the following: Texas Labor Code §§ 413.016(a), 413.019(b), 413.031(a)(3) and 408.0271; 29 TAC §§ 133.260, 133.305(a)(4)(C), 134.800(f) (repealed) and 133.304 (repealed). Please let me know if you required any additional information to process this dispute."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
04/15/2009 – 04/07/2010	No EOBs or denials presented	Out-of-Pocket expenses for Prescription Medications	422.36	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

* The amount in dispute reflects the subtraction of $25.44 for date of service 02/20/2009 as noted below in paragraph 1.

1. Medical Fee Dispute Resolution received the request for medical dispute resolution on April 26, 2010. Date of service 02/20/2009 was not filed within the one-year filing time as required by 28 Texas Admin Code Section §133.307(c)(1); therefore, this date of service will not be reviewed.

2. This dispute relates to out-of-pocket expenses with reimbursement subject to the provisions of 28 Texas Admin Code Sections §133.270 and §134.504.

3. The Carrier response, submitted by Flahive, Ogden & Latson on May 17, 2010, did not deny or pay the out-of pocket expenses incurred by the injured worker. The injured worker has submitted receipts showing out-of-pocket payments for prescription medication for dates of service 04/15/2009 through 04/07/2010.

4. According to 28 Texas Admin Code Section §133.307(c)(3)(D) a copy of the carrier's denial of reimbursement relevant to the dispute, or, if no denial was received, convincing evidence of the employee's attempt to obtain reimbursement from the carrier. The Requestor has not submitted a denial from the carrier nor convincing evidence the out-of-pocket expenses were submitted to the carrier for reimbursement.

5. Pursuant the 28 Texas Admin Code Section §133.307(e)(3)(J) the Division concludes that this dispute was submitted prematurely. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270, §133.305, §133.307, and §134.504

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		July 6, 2010
Authorized Signature	Auditor III Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.